Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRESBYTERIAN PLANO CENTER FOR DIAGNOSTICS AND SURGERY
P O BOX 676266
DALLAS TX 75267

Carrier's Austin Representative Box
47

MFDR Date Received
NOVEMBER 7, 2005

Respondent Name
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-06-1785-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I initially submitted a claim for processing and payment of our claim, completed appeal to Hartford Insurance, which supplied all the necessary documentation to perform a valid and correct audit. Unfortunately, a fair audit was not performed, because we only received a payment of $1,118.00 for our entire claim, so I contacted Hartford Insurance and spoke to Peter Tarnacki, claims supervisor, who told me that the claims were paid fair and reasonable, based on a methodology that Hartford Insurance reflected off the TWCC daily in-patient Per Diem of $1,118.00."

Amount in Dispute: $8,165.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Respondent did not submit a response to this dispute.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 26, 2005 Through May 27, 2005	Inpatient Hospital Services	$8,165.34	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

4. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- W1 – WORKERS COMP STATE FEE SCHED AJUST. SUBMITTED SERVICES WERE RERPRICED IN ACCORDANCE WITH STATE PER DIEM GUIDELINES.
- W1 – WORK COMP ST FEE SCHEDULE ADJ RX ADMINISTERD DURING ADM AND GREATER THAN $250 CHARGED PER DOSEE [SIC] SHALL BE REIM. AT COST PLUS 10% ELSE INCLUDED IN THE PERDIEM RATE PER THE TX ACUTE CARE INPATIENT HOSP FEE GUIDELINE.
- W1 – WC STATE FEE SCHED AJUST. SUBMITTED SERVICES ARE CONSIDERED INCLUSIVE UNDER THE STATE PER DIEM GUIDELINES.
- O – REIMBURSEMENT FOR YOUR RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCODRING [SIC] TO STATE FEE GUIDELINES AND/OR STATE RULES AND REGULATIONS.
- * – FIRST HEALTH NETWORK OWNED/ACCESSED

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason "FIRST HEALTH NETWORK OWNED/ACCESSED." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(1) states "The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401 (c)(2)(A) states "All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical and surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401 (c)(3)(A)(i and ii) states "Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical). The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission."

3. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was one day. The surgical per diem rate of $1,118 multiplied by the length of stay of one day results in an allowable amount of $1,118.00.

   The division concludes that the total allowable for this admission is $1,118.00 per diem. The respondent issued payment in the amount of $1,118.00. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. As a result no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.